Mental Health Series

Disease Management and Mental Health

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INTRODUCTION

Disease Management (DM) programs have offered their services for about ten years, with many companies in existence for at least five years. The growth in the number of Disease Management Organizations (DMO), as well as the number of medical conditions targeted for management, has increased dramatically since 1998.[1,2] To date, one of the most effective means to gauge success of DM companies and programs is to analyze feedback from users and recipients of the services offered in DM project.[3-5]

DEFINITION

In general terms, disease management can be defined as a "set of interventions designed to improve the health of individuals, especially those with chronic diseases."[6] The goal of DM is to deliver quality care. The objectives are to reduce or delay clinical problems and disadvantages in daily functioning that could result from chronic diseases and reduce the cost of medical care. Evidence-based guidelines are often relied upon when trying to prevent or minimize complications from chronic diseases.[7,8] There is no standard or universal set of guidelines used by all DM companies and programs. Instead, most DM companies and programs use various clinical protocols and guidelines accepted in the respective field of medical practice for the type of illness, such as cardiology or infectious disease. Thus, a single identifiable and nationally defined body of experts does not exists.[1]

The Disease Management Association of America (DMAA) has outlined the components of DM to include: (1) population identification processes; (2) evidence-based practice guidelines; (3) collaborative practice models to include physician and support-service providers; (4) patient self-management education activities (including primary prevention, behavior modification programs, and compliance/surveillance); (5) process and outcomes measurements, evaluations, and management techniques; and (6) routine reporting/feedback loops which include communication procedures with patient, physician, healthcare and other providers, as well as medical practice profiling.[2,8]

Initially, DM companies and programs focused on specific physical illnesses, i.e., diabetes, asthma, heart (cardiac) diseases, and high blood pressure/hypertension.[2,8] Eventually, the focus was to have DM projects treat more than a single physical illness of individuals within selected population resulting in treatment of comorbidity diseases, illnesses, and disorders. Thus, DM treatment projects began combining emotional with mental illnesses and disorders with physical illnesses, e.g., treatment of heat disease with depression. Thus, the paradigm shifted to encompass a focus on the quality of life for individual patients rather than grouping patients into a fixed healthcare treatment program that was cost-effective, such as Health Maintenance Organizations (HMOs) and Managed Care Organizations (MCOs).[7,9]

CHARACTERISTICS

The Milliman Foundation Research Report of 2003 outlined four methods which DM programs and companies have used to identify an eligible user population (establishment of membership):

1. *Health Risk Assessment Forms* – request to recipients of service(s) and members to voice specific symptoms for analysis, with follow-up by phone regarding benefits the service recipients have noticed since participating in the program.
2. *Predictive Modeling* – analyzing patterns of diagnostic and procedural treatment claims' data (e.g., algorithms, best practices guidelines, PACTS (Programs for Assertive Community Treatments).
3. *Referrals* – in this research report, referrals by physicians, home care professionals, and family members, was not a major reason to seek and continue eligibility or membership in a DM project.
4. *Claims Analysis* – a search by claims for types of diseases listed in diagnostic category code books (e.g., **ICD-9, CPT-4, HCPCS** and **DSM-IV)**.[1]

For the Milliman report, membership status and eligibility of individuals and service recipient populations were defined by the strategy the DM project used. Type of strategies were categorized as follows:

1. 'Internal Development' ***(buy)*** – when a program is developed from within for existing members;
2. 'Carve Out' ***(collaborate)*** – when the company (DMO) is contracted to provide and administer a DM program; or
3. 'Carve In' ***(build)*** – when a company (DM or other service provider) is hired to develop a DM program, while the contracting administration (authorized representatives of members or eligible service recipients) is the buyer.[5,7]

In regards to the 'internal development' strategy, a distinction is made about pharmaceutical companies, whether the company is operating as a DM company or simply providing funding to support services.[7]

Further, as regards the third category, the term 'carve outs' is defined as allowances of payment for services separately, on either a capitated or fee-for-service (FFS) basis. In this category, for health plans the carve out strategy produces limited exposure to cost associated with unusually large numbers of enrollees or

high-risk factors of individuals. Also, carve outs allow states to avoided interagency disputes. Currently, many healthcare programs continue to carve out mental health services. In 2003, one survey reported that some states carving out mental health services and treatment tended to carve out completely, while others states that carved out mental health services limited visits and inpatient days. Findings from a 2001 survey reported a carve out of 72% for mental health services and 61% for substance abuse services of states carving out services.[10]

THE STATES AND MENTAL HEALTH DISEASE MANAGEMENT

Disease Management Medicaid/ Medicare test programs in Mental Health: The following are examples of strategies used in DM programs within the United States that have initiated DM mental healthcare programs. The examples are for the states of Texas (internal), Colorado (carve out) and Florida (build). Each of the descriptions list the implementation dates.

TEXAS STRATEGY (INTERNAL DEVELOPMENT)

Dates of Programs: 1999-2001 (Diabetes); 2002-2005 (Mental Health)

- The Texas Department of Mental Health and Mental Retardation, Texas medical schools and universities (in consortium), and consumer advocacy organizations developed a treatment program utilizing evidence-based treatment algorithms for patients with schizophrenia, major depressive disorders and bipolar disorder. The outcome was the development of the Texas Medication Algorithm Project (TMAP).
- This treatment program was created to redesign the State of Texas mental health system, which delivered services to adults with Severe Persistent Mental Illness (SPMI), and children with Severe Emotional Disturbance (SED), subsequently named the "resiliency and disease management" program. The goals were to: (a) implement a utilization management system and review clinical needs and match services with needs; (b) employ evidence-based practices; and (c) increase accountability by local authorities for local management of limited resources.
- The Benefit Design project to initiate this DM program set out to define specific services by level of care; use evidence-based protocols in treatment programs and services; use clinical diagnosis and functioning levels for assignment of levels of care; establish guidelines for admission, discharge, and term of stay with a utilization management methodology; and establish and utilize an ongoing assessment of clinical outcomes for follow-up and evaluation of the DM program.[3,4]

COLORADO STRATEGY (CARVE OUT)

Dates of programs: 2002 to present and ongoing (Schizophrenia)

- "In 2002, the Colorado General Assembly enacted legislation authorizing the Department of Health Care Policy and Financing to develop disease management programs 'to address over- or under-utilization or the inappropriate use of services or prescription drugs, and that may affect the total cost of healthcare utilization by a particular Medicaid recipient with a particular disease or combination of diseases.' "[5]
- The program revolves around three managed care principles: appropriate and timely access to healthcare services; evaluation and support for adherence to appropriate medical regimes/treatments; and provision of nationally recommended practice guidelines for each chronic disease. All funding for the pilots are provided directly to the vendors of the DM programs by the pharmaceutical companies funding the programs.
- Colorado Medicaid may be the first Medicaid program integrating its mental health component into its disease management program. The total number of clients to be enrolled in this pilot is 250 with a rolling enrollment.
- The Colorado Department of Health Care Policy and Finance has entered into a public-private partnership with several pharmaceutical companies to provide services to mental health recipients.
- Summary Information: Private Funding Source – Eli Lilly; DM Vendor, Specialty Disease Management Services; Implementation date was July 2002; Duration will be 12 to 18 months; Enrollment has been set at 250 to 260 on a rolling admission basis.[1,2,5,7]
- By December 2003, it was still too early to determine the fiscal impact of the individual program, as adequate time had not yet elapsed by any claims assessment.[11]

FLORIDA STRATEGY (BUILD/DEVELOPED IN COLLABORATION/PARTNERSHIP)

Dates of programs: 1998 to present and on-going: (Asthma, HIV/AIDS, CHF, Hemophilia, ESRD, Diabetes, Hypertension, Pre-Diabetes, Depression)

- Florida contracted with pharmaceutical companies to launch DM programs for asthma, diabetes, HIV/AIDS, hemophilia, end-stage renal disease (ESRD), congestive heart failure, chronic obstructive pulmonary disease, and mental health. These programs have been implemented in various stages annually since 1997. Further, an 'in-house' initiative, working through community faith-based outreach model programs, has been targeted for mental illness in the minority population collaborating of health professionals, social workers, and lay-health workers. This was implemented by the state's Medicaid program.[2,12,13]

CONCLUSION

DM programs have been developed in various states over the last ten years. Although their focus has been on physical illnesses; recent programs have been instituted which focus upon mental health disorders. To determine the overall effectiveness and cost savings, further studies will eventually need to be conducted on mental health disorders. The

Center for Medicaid/Medicare Services (CMS) February, 2004 letter from Dennis Smith, Acting Administrator of CMS, announced to state Medicaid officials CMS would match state costs of running DM programs aimed at improving health outcomes while lowering the medical costs associated with these diseases.' States may contract with a DMO that would manage the overall care of the beneficiary, but does not restrict access to other Medicaid services. Further, "a state may pay the DMO a capped amount per beneficiary while the organization becomes responsible for any expenses over the set amount"[6]

Considering the current state of healthcare, DM companies and programs offer a potentially workable solution, which could "curb or reduce spending without limiting Medicaid enrollment, cutting benefits, increasing premiums or copayments, or reducing provider reimbursement rates." DM has the potentially to provide a long-term solution to affect the direction of Medicaid programs, bringing about cost-effective solutions and clinical quality care to those who are in need of long-term mental health treatment.[13]■

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